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ABSTRACT

To obtain information concerning interagency agreements which use the resources of various state agencies to serve handicapped children, state agency officials in Connecticut and Maryland responsible for establishing and implementing such agreements were interviewed by Government Accounting Office officials, and pertinent documents were reviewed. In Connecticut, information was obtained on agreements: (1) to obtain third-party reimbursement to local school districts for school-based health services to handicapped students; and (2) to allow the state Departments of Children and Youth Services and of Education to share care and education costs of handicapped children in residential care. In Maryland, information was obtained regarding an executive order designed to encourage interagency cooperation through use of coordinating councils at the state and local levels which review recommendations for residential placements. This document includes state views about factors essential to establishing and implementing such interagency agreements (sufficient authority needed, agency official commitment, planning and lead time, commitment of resources). Legislative language designed to clarify financial responsibility for required services, encourage the use of interagency agreements, and eliminate obstacles to the use of such agreements requested by the subcommittee is presented. Advance comments from the United States Department of Education and Department of Health and Human Services regarding this report are appended. (CB)

ED276185

United States General Accounting Office

GAO

Briefing Report to the Chairman, Subcommittee on Select Education, Committee on Education and Labor House of Representatives

July 1986

SPECIAL EDUCATION

Financing Health and Educational Services for Handicapped Children

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
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United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-220989

July 31, 1986

The Honorable Pat Williams
Chairman, Subcommittee on Select Education
Committee on Education and Labor
House of Representatives

Dear Mr. Chairman:

This report on financing special education services for handicapped children is submitted in accordance with your request of June 5, 1985, and subsequent discussions with your office. In it, we address your concern that the Education for All Handicapped Children Act of 1975 (Public Law 94-142) has resulted in state and local education agencies assuming responsibility for financing a wide variety of services to such children.

Initially, we briefed staff from your office on information we obtained from seven states and discussed the use by states of interagency agreements to utilize the resources of various state agencies to serve handicapped children. We agreed to then (1) obtain information on the use of such interagency agreements in two selected states and obtain state officials' observations on the value of such agreements, (2) draft legislative language that would encourage such agreements and eliminate possible legal impediments to their use, and (3) give you a final briefing on that information.

This report documents and expands somewhat on information from our earlier briefings to your staff. In its preparation, we met with officials from Connecticut and Maryland who establish and implement interagency agreements. We selected these states in consultation with your office and as a result of information given us by the Department of Education.

In both states, the agreements demonstrate that state agencies with various responsibilities for serving handicapped children can work together and share the cost of needed services:

--In Connecticut, about $5 million per year in Medicaid reimbursements will be made available to local school districts for school-based health services to handicapped children, a state education official estimated. In the recent past, local school districts paid for these health services.

--In Maryland, its interagency agreement has resulted in health and social service agencies contributing over $11 million to a fiscal year 1986 state funding pool to cover the costs of placing handicapped children in residential facilities, state officials estimated.

These agreements do not necessarily represent the best nor the only methods of interagency cooperation available. Because individual states have unique organizational structures and educational needs, the nature of needed interagency cooperation could vary.

The legislative language we developed would clarify financial responsibility for services required and encourage the use of interagency agreements through revision to the Education of the Handicapped Act. We also include in this report draft language that would amend title XIX of the Social Security Act so as to not preclude the use of Medicaid funds for health services, such as speech pathology and audiology, that would otherwise be covered by Medicaid if not listed in an individual education plan. GAO neither supports nor opposes any of the changes contemplated in the legislative language it was asked to develop.

In commenting on a draft of this report, the Departments of Health and Human Services (HHS) and Education generally opposed any amendment that would shift any costs now borne by state and local education agencies to the Medicaid budget. Education said that education and related services included in a handicapped child's individual education plan should be the responsibility of the state education agency, not Medicaid. The amendments are not intended to shift education costs to Medicaid. Rather, they do not preclude health costs from being paid by Medicaid to the extent they would otherwise be covered by Medicaid had they not been listed in an individual education plan.

Regarding interagency agreements, while not opposing the draft amendments providing for such agreements, Education said they were not needed because its regulations already provide for them. Technical comments were also provided by Connecticut and Maryland state officials; where appropriate, we incorporated these.

As agreed with your office, copies of this report are being provided to the Secretaries of the Department of Education and HHS, appropriate congressional committees, state officials in Connecticut and Maryland, and other interested parties.

Sincerely yours,

Richard L. Fogel

Richard L. Fogel
Director

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ABBREVIATIONS

GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
ICF/MR	intermediate care facility for the mentally retarded
IEP	individual education plan

SPECIAL EDUCATION:

FINANCING HEALTH AND EDUCATIONAL SERVICES

FOR HANDICAPPED CHILDREN

BACKGROUND

The Education for All Handicapped Children Act of 1975 (Public Law 94-142)[1] requires state education agencies to assure that all handicapped children, regardless of the nature or severity of their handicapping condition, have available to them a "free and appropriate" public education. For many such children, "appropriate" includes special education and "related services" that must be provided in conformity with the child's individualized education program.

Special education, as defined in Public Law 94-142, means "specially designed instruction, at no cost to parents or guardians, to meet the unique needs of a handicapped child, including classroom instruction, instruction in physical education, home instruction, and instruction in hospitals and institutions." For the severely handicapped child, the concept of education has been broadly defined by the courts. For example, in Kruelle v. New Castle County School District, 642 F. 2d 687 (1981), the court stated that "where basic self-help and social skills such as toilet training, dressing, feeding and communication are lacking, formal education begins at that point."

Related services, as defined in Public Law 94-142, means "transportation, and such developmental, corrective, and other supportive services (including speech pathology and audiology, psychological services, physical and occupational therapy, recreation, and medical and counseling services, except that such medical services shall be for diagnostic and evaluation purposes only) as may be required to assist a handicapped child to benefit from special education, and includes the early identification and assessment of handicapping conditions in children."

When the act was passed more than 10 years ago, it authorized a maximum federal share for special education in 1982 of 40 percent of the average per pupil expenditure for public elementary and secondary schools nationwide. Currently, however, the federal share stands at only about 10 percent. State and local education agencies, required to assure the availability of various services, have had to assume greater financial responsibility for educationally related services, according to several state and local education officials. This is due in part to

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[1]Public Law 94-142 amended the Education of the Handicapped Act to provide educational assistance to all handicapped children.

interpretations of the act by various federal and state health and other human services agencies to mean that the assurances it requires include the payment of all the costs of such services. Consequently, the position of these agencies is that the cost of educationally related services should be borne solely by state education agencies, despite the availability of funds for services to handicapped children under some noneducation programs, such as title XIX of the Social Security Act (Medicaid).

Medicaid authorizes early and periodic screening, diagnosis, and treatment for children in low-income families. Under this program, states must provide or purchase care and services necessary to screen, diagnose, and/or treat individuals under the age of 21 who are members of families Medicaid designates as "categorically needy." To avoid having the various education agencies pay for all educationally related services, including those better described as health services, the state department of education, in some states, has initiated interagency agreements with other state departments (usually health and/or social services) to spread among the parties to the agreement the responsibility for providing and financing "educationally related services" to handicapped children.

In November 1985, we briefed staff from the House Subcommittee on Select Education regarding states' use of interagency agreements to get other agencies to provide their share of services to handicapped children. This report elaborates upon the material provided during that briefing.

OBJECTIVES, SCOPE, AND METHODOLOGY

Pursuant to a request of June 5, 1985, from the Chairman of the Subcommittee on Select Education, House Committee on Education and Labor, and subsequent agreements with the subcommittee office, we developed information concerning the establishment and implementation of interagency agreements in two states that have active agreements. We were also asked to draft legislative language to change existing law so as to encourage the use of interagency agreements, eliminate impediments to their use, and clarify what entities have financial responsibility for services required under Public Law 94-142.

To develop information concerning interagency agreements and identify states with such pacts, we consulted with U.S. Department of Education officials, education officials in various states,[2] and education experts. Based on our consultations and as agreed with subcommittee staff, we selected Connecticut and Maryland because their state agencies were identified as active

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[2]Connecticut, Illinois, Maryland, Michigan, Nebraska, New York, and Ohio.

participants in establishing and implementing interagency agreements. To obtain information regarding these agreements, we visited state agency officials responsible for their establishment and implementation and reviewed pertinent documents. We did not, however, verify the cost, funding, and enrollment data given us by the officials. In addition, we attended two meetings of Maryland interagency coordinating councils concerned with residential placement of handicapped children. The residential placements considered under the Maryland process are for children whose needs cannot be appropriately met in a community program, including foster parent or group home placement.

In Connecticut, we obtained information on two agreements that use resources of the state Department of Education and other appropriate agencies to help finance services to handicapped children. These agreements were established to

--obtain third-party reimbursement to local school districts for school-based health services to handicapped students and

--allow the state Department of Children and Youth Services and of Education to share costs of care and education for handicapped children in residential care.

In Maryland, we collected information on an executive order designed to encourage interagency cooperation through use of interagency coordinating councils at the local and state levels to review and approve recommendations for the placement of handicapped children requiring residential placements to receive care, treatment, and education services.

Also, we obtained state officials' views on the factors essential to establishing and implementing interagency agreements.

In drafting the requested legislative language to clarify financial responsibility for services required, encourage interagency agreements, and eliminate legislative impediments to their use, we reviewed applicable federal statutes, court rulings, and administrative decisions.

CONNECTICUT INTERAGENCY AGREEMENTS

In Connecticut, we obtained information on two interagency agreements: a third-party billing system and a cost-sharing arrangement between the Department of Education and the Department of Children and Youth Services for residential placements of handicapped children. How each agreement works, its current status, and other pertinent issues are discussed below.

Third-Party Billing System

Many handicapped students in Connecticut need health services to benefit from their education program. Most special education students have some type of health insurance coverage and/or are Medicaid-eligible. To recover the cost of providing health services to these children, Connecticut has an interagency agreement between its Departments of Education and Income Maintenance to jointly implement a third-party billing system and a school-based child health services policy. Prior to this agreement, school districts generally arranged to provide and pay for educationally "related" health services without seeking reimbursement from private health insurers and/or the Medicaid program. Connecticut's "billing system" is an attempt to use such third-party funds.

It took approximately four years to develop the billing system, officials from Connecticut's Departments of Education and Income Maintenance explained. The two agencies worked with Connecticut's Office of Policy and Management--the state's primary budget and planning agency--to ascertain the value of this process for state and local governments and to obtain gubernatorial concurrence for implementing the system. In August 1983, the interagency agreement was formalized and approved. The billing system became operational in September 1984, with the Bridgeport School District as its first pilot district.

How the process works

Before Connecticut's third-party billing system was implemented, according to a state education official, two preliminary steps were taken:

1. At the joint request of the Departments of Education and Income Maintenance, the governor authorized allocation of additional state funds for reimbursing providers under Medicaid. (The Medicaid program uses state and matching federal funds, the latter ranging from 50 to 83 percent depending upon the state's affluence. As Connecticut matches federal Medicaid funding on a 48/52-percent basis, the Department of Income Maintenance needed additional state funds to allow for the projected increase in federal Medicaid funding.)

2. The Department of Education contracted with a central billing agent (one of the state's regional educational service centers, the Capitol Region Education Council), to implement and control the billing process.

Once these tasks were accomplished, a certain number of school districts were designated to participate in the third-party billing system. Before it could bill third parties as part of the program, however, a district had to meet certain documentation requirements, among them:

--Service providers within the district (i.e., clinicians in speech, hearing, and language services, physical and occupational therapy, and mental health) must apply to the Department of Income Maintenance. Upon meeting the department's standards, they are enrolled as providers of school-based health services and assigned Medicaid provider numbers.

--The district must obtain permission and enrollment information from each handicapped child's parent/guardian to permit the district to bill the respective insurers and, if applicable, Medicaid for school-based health services. A family's participation in the project is strictly voluntary. If parents choose not to grant permission, their children still receive the same level of services.

--The district must submit a plan for the establishment of third-party billing procedures to the state Board of Education.

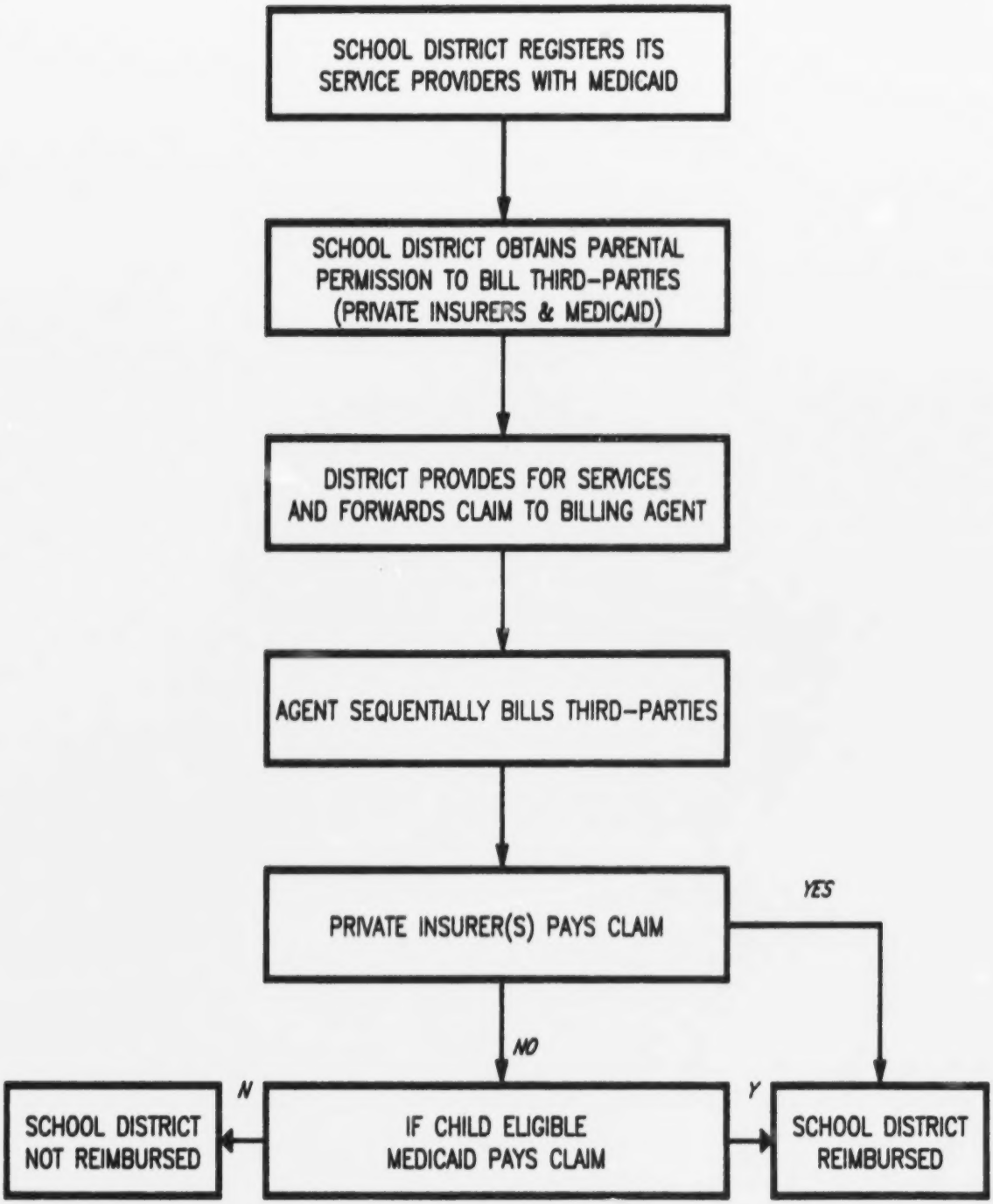
To participate in the billing system, each participating school district arranges to provide the health services according to its usual special education procedures and reports them to the billing agency for processing. The billing agent prepares claims for services provided and submits them to the child's insurers in the appropriate sequence, i.e., private coverage first and Medicaid last, according to Medicaid regulations. If the claim is paid in full by one of the insurance carriers, the billing cycle is complete and the school is reimbursed. If the parent/guardian has an insurance policy with a copayment or deductible clause, the school district absorbs the cost of the copayment and/or deductible and is reimbursed for the balance. If the claim is denied or partially paid and the child has additional coverage, the claim is sent to the next level of insurer.

If private insurers who are billed refuse to pay the claim because it is a noncovered service and the handicapped child is Medicaid-eligible, the claim is then submitted to Connecticut's Department of Income Maintenance for reimbursement from Medicaid funds. The Department of Income Maintenance follows Health Care Financing Administration (HCFA) requirements concerning payment

policies as reflected in the state medicaid plan and fee schedules for Medicaid reimbursement of school-based health services. Therefore, once Income Maintenance accepts a claim, it will pay the lower of the amount billed or the Medicaid-allowed fee.

Connecticut's third-party billing system is a reimbursement system, state Department of Education officials emphasized, and if all requests for reimbursement are denied, the school district must absorb all costs of providing the health service. The billing process is illustrated in figure 1.

FIGURE 1
CONNECTICUT'S THIRD-PARTY BILLING PROCESS


SCHOOL DISTRICT REGISTERS ITS SERVICE PROVIDERS WITH MEDICAID
SCHOOL DISTRICT OBTAINS PARENTAL PERMISSION TO BILL THIRD-PARTIES (PRIVATE INSURERS & MEDICAID)
DISTRICT PROVIDES FOR SERVICES AND FORWARDS CLAIM TO BILLING AGENT
AGENT SEQUENTIALLY BILLS THIRD-PARTIES
PRIVATE INSURER(S) PAYS CLAIM
YES
NO
N
Y
SCHOOL DISTRICT NOT REIMBURSED
IF CHILD ELIGIBLE MEDICAID PAYS CLAIM
SCHOOL DISTRICT REIMBURSED

Current status and impact

As of December 31, 1985, the third-party billing system was in its pilot phase with 8 of Connecticut's 165 school districts participating and 1,172 students enrolled. While these 8 districts represented about 70 percent of Connecticut's handicapped Medicaid-eligible students, only a small percentage of the total handicapped child population had been asked to participate in the billing system. Connecticut has over 20,000 Medicaid-eligible handicapped children who could be served using the third-party billing system, a state education official estimates. Most are also covered by private group health insurance. Although student participation is now low, a billing system official said, the computer billing system was designed to serve all school districts in the state.

Reimbursements received by the eight school districts participating in the system from September 1, 1984 (the system's start) to December 31, 1985, appear in table 1. The figures are drawn from a status report prepared by the billing agency.

Table 1:

Total Reimbursements of Connecticut's Third-Party Billing System (Sept. 1, 1984, to Dec. 31, 1985)

Source	Reimbursement
Medicaid	$138,350
Private insurers	3,181
Total	$141,531

When the billing system is fully operational across the state, a Connecticut Education official has estimated it could return to the school districts approximately $5-6 million per year in Medicaid reimbursements alone. This estimate was based on Connecticut's projected handicapped Medicaid-eligible youth population and expected services.

The offices of legal affairs of the state Departments of Education and Income Maintenance have reviewed the third-party billing system, departmental officials said, and believe it to be legally sound. One official expressed concern, however, that impediments that would render Medicaid reimbursement under the system vulnerable to legal challenges could develop. For example, HCFA, in a September 1985 transmittal, said that services required under education laws in intermediate care facilities for the mentally retarded (ICFs/MR) would not be reimbursed under

Medicaid, nor would services in an ICF/MR required by an individual education plan (IEP). The Connecticut official was concerned that, were this policy extended beyond ICFs/MR to the public school system, many services now being reimbursed by Medicaid under the interagency agreement would be ineligible for coverage.

Use of exclusionary clauses by insurance companies to deny reimbursement

Several insurance companies have interpreted the Education of the Handicapped Act to mean that the state education agency is financially responsible for providing and financing all special education services, according to Connecticut officials. These companies have policies containing exclusionary clauses stating that the company will not pay for health services that are available free of charge, the officials said. Due to insurers' use of these exclusionary clauses, local school districts have had difficulty obtaining reimbursements from insurance companies for health-related services delivered by the school system. Several insurance companies have denied claims for reimbursement, according to Connecticut officials, and companies that do pay the claims tend to be smaller firms.

A Connecticut Department of Education official believes that the use of exclusionary clauses poses a threat to the success of the third-party billing system. The state Attorney General's office has been asked to review the legality of such clauses, the official said.

Interagency Cost-Sharing Arrangement

Of the approximately 62,000 handicapped children in Connecticut, 2,100 (about 3.4 percent) were receiving services in some form of residential treatment facility during the 1983-84 school year. In Connecticut, local school districts are responsible for all or part of the costs associated with residential care of handicapped children within their jurisdiction. Financial responsibility is borne entirely by the local school district or split between the district and Connecticut's Department of Children and Youth Services, depending upon whether the placement is primarily for educational or habilitative purposes. Due to various circumstances, however, it is sometimes difficult to identify a child with a particular local school district. To avoid conflicts in assigning costs of residential care for children who could not be easily assigned to a specific school district, the Departments of Education and Youth Services agreed to split the costs of these placements. Officials from both departments said it took several months of cooperative effort between them to develop and agree upon a residential cost-sharing arrangement for children not identified with a specific district. The agreement went into effect during the 1983-84 school year, according to a state Education official.

How the process works

To identify which agency is financially responsible for a child's residential care, the Departments of Education and Youth Services identify handicapped children requiring residential care in one of two categories--"nexus" or "no nexus." These categories describe whether a child can be legally tied to a local school district, based on the legal relationship of the child to its parents and the parents' residence in a Connecticut community, as follows:

--Nexus refers to children who can be legally identified with a particular district. During the 1983-84 school year, state education officials reported, 1,975 handicapped nexus children were placed in residential care. The cost of such placements is borne by either the district or both the district and the Department of Youth Services, depending on the reason for placement.

--No nexus refers to children who cannot be legally tied to a particular school district and are placed for residential purposes. These children typically include orphans, wards of the state, or children whose parents are in state correction or mental health facilities and do not maintain a Connecticut residence. During the 1983-84 school year, state education officials reported, 155 handicapped no nexus children were placed in residential care. Since these children could not be identified as residing in a specific district, officials of the Departments of Education and Youth Services said they were often unsure as to who was financially responsible for educating them.

To avoid conflicts in attempting to assign financial responsibility for these handicapped no nexus children, the Connecticut Departments of Education and Youth Services established an interagency agreement to split the children's placement costs, viewing 45 percent as educational and 55 percent as daily living/residential. Therefore, Education would pay 45 percent and Youth Services 55 percent. Youth Services places the no nexus children and pays all residential care costs, billing Education for its 45 percent share, Youth Services officials said.

Current status and impact

According to Connecticut Education and Youth Services officials, this agreement has eliminated considerable conflict over who is responsible for the residential care costs of no nexus children. In addition, it has shifted some of the local education agency's financial responsibilities for providing services to the state Departments of Education and of Youth Services.

During the 1983-84 school year, Connecticut paid about $1.9 million for the residential care of no nexus handicapped children. Of this, about $900,000 was paid by Education and about $1.0 million by Youth Services.

Although this interagency agreement reportedly has helped to increase cooperation and reduce the financial responsibilities placed on local school districts, it only pertains to a small segment of Connecticut's handicapped student population, about 0.2 percent. It illustrates, however, that interagency agreements can enhance cooperation, increase coordination, and help provide various agency resources to serve handicapped children.

MARYLAND INTERAGENCY AGREEMENT

In Maryland, we obtained information on an interagency process that would establish a statewide system of interagency service coordination and decision-making for placing handicapped children in residential care. The purpose of the process is (1) to develop and maintain a uniform, coordinated, state-wide procedure for determining funding for residential programs for handicapped children and placing them in such programs; and (2) to assure that all handicapped children in residential programs have an interdisciplinary plan of care, treatment, and education provided in the least restrictive environment that is appropriate.

Maryland incurs substantial costs for the relatively small number of students placed in residential care facilities, state Education officials told us. For example, for fiscal year 1984, the state reported 368 students in these facilities at an average cost of $24,122 per student. In fiscal year 1985, according to one official, $7 million was budgeted for residential care from the $77 million in state education funds for handicapped students.

Authority to establish the Maryland agreement came from a series of executive orders from the governor. The initial order, issued in 1978, directed the state's major service agencies to study the need for and feasibility of establishing an interagency coordinating council. The most recent order (1982) established the current system, which began operation in July 1983.

To develop interagency procedures, the agreement establishes local coordination councils for residential placement of handicapped children in each county and Baltimore City. The councils review the needs of children thought to require residential services in a program above the level of foster family care or a group home. Through an examination of local resources, the counsels consider alternative options in less restrictive settings. The executive order establishes a state coordinating council that reviews local council recommendations for residential placements. The state council may either identify funding from a state interagency funding pool for appropriate services or return the recommendation to the appropriate local council for further consideration of a less restrictive alternative.

Local Councils

Each local council is composed of local representatives from various agencies that may become involved in providing residential care for handicapped children or needed services in lieu of residential programs. Members have the delegated authority to commit the resources of their respective agency. Represented are

the local education agency, the state Departments of Human Resources and Health, the state Juvenile Services Administration, and the state Mental Retardation and Developmental Disabilities Administration.

Local councils usually meet monthly, Maryland officials said, or as frequently as necessary to review a child's needs to determine if he or she needs a residential program for care, treatment, and education. The councils are responsible for

--exploring less restrictive alternatives to intense residential placements and when appropriate using alternatives to provide needed services to the child and family within the same community;

--in developing a recommendation for program placement, reviewing the child's needs including social, family, medical, mental health, education, and rehabilitation needs;

--reviewing available and appropriate community-based resources and examining each agency's financial resources to secure needed services;

--recommending residential placement when appropriate to the state council;

--assigning a case manager or service coordinator to implement and monitor residential care and act as a liaison to appropriate agencies and to families;

--developing transition plans to place children in less restrictive environments when goals of residential care are met; and

--developing a transition plan for adult services for students leaving the program.

State Council

The state coordinating council for residential placement of handicapped children is composed of five members. The Maryland Departments of Education, Human Resources, and Health and Mental Hygiene each have a member on the council. Each member has (1) a role in identifying less restrictive placement options in which needed services can be met and (2) authority to commit resources of his/her respective department and participate in funding decisions to use funds from the interagency funding pool to cover the costs of residential care. The state council also includes representatives of the governor's and the attorney general's offices, who serve as ex-officio nonvoting members.

The state council meets monthly or as often as necessary to render decisions regarding children recommended for residential placement. Its responsibilities include (1) approving recommendations for residential care from local councils, (2) authorizing payment for residential care out of the interagency funding pool, and (3) monitoring local council activities to oversee programs for children in residential care facilities. The funding pool for fiscal year 1986 includes funds from each of the participating state agencies (see table 2), according to the executive director of the state council.

Table 2:

Maryland Coordinating Council Interagency Funding Pool for Residential Care (Fiscal Year 1986)

State agency	Amount budgeted (millions)
Education	$ 7.1
Human Resources	3.1
Health and Mental Hygiene	1.5
Total	$11.7

According to state council representatives, almost all funds used in the pool come from the state general fund and are generated from state sources. The only federal money in the pool consists of a small portion ($282,000) of the $3.1 million in Human Resources funds, according to that agency's council representative. If all pool funds are spent, supplemental funding can be requested.

How the Process Works

Candidates for residential care can be proposed to a local council by any of its participating agencies. Using a standard planning document, participating agencies submit records for children who may need multiagency services and residential placement to the local councils. For children proposed by the education agency, these records must include the child's individual education plan. Local councils may need additional information concerning the child's needs (social, emotional, and educational) and family status in order to consider possible residential programs. If such information is needed, constituent agencies secure it through the established programs. The local council then examines the information to determine if appropriate services are available locally or if it needs to recommend residential placement to the state council. If the local council process results in changes to a child's IEP, the IEP must be

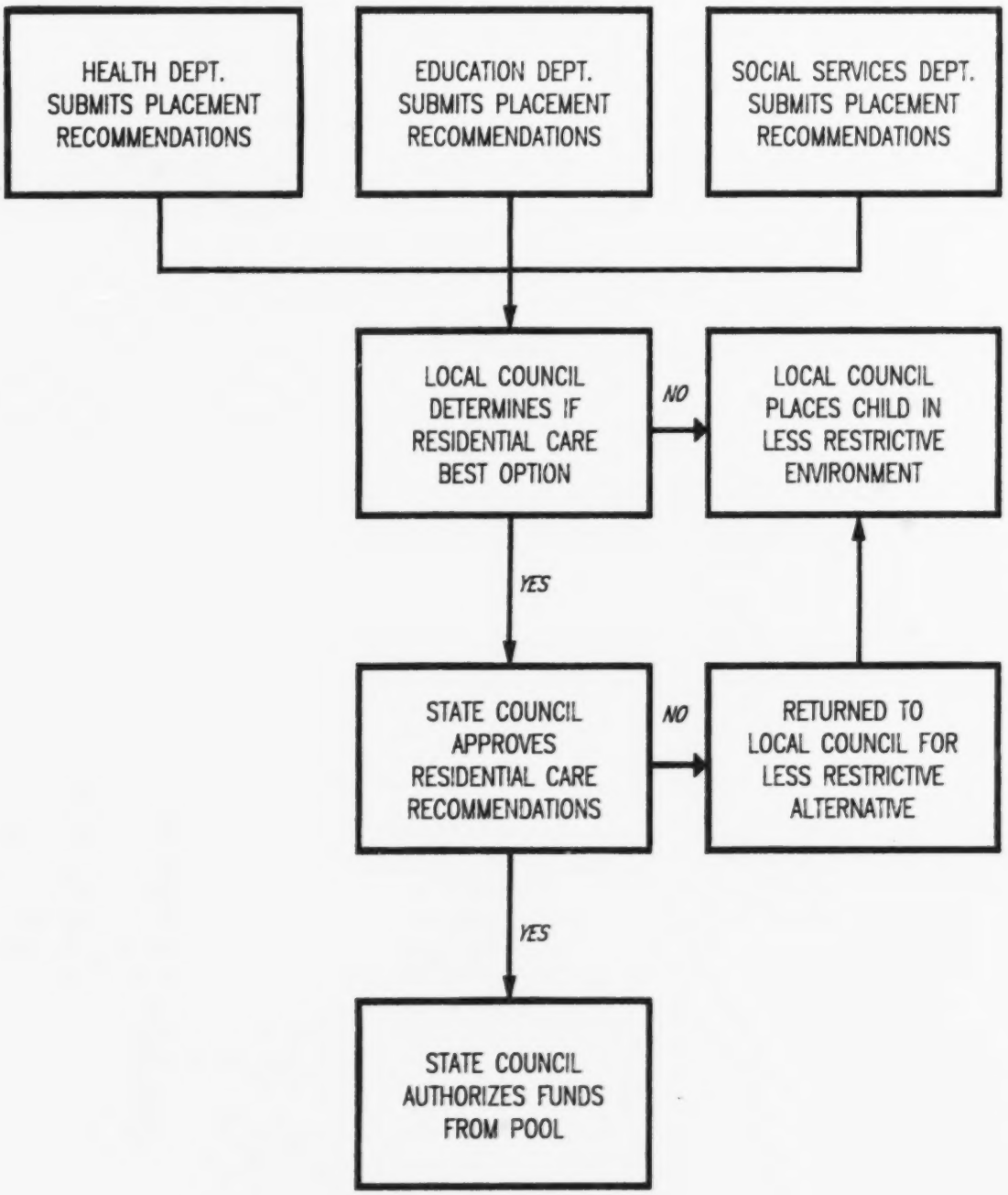
amended in accordance with established procedures, an education official explained.

Throughout the process, parents are given opportunities for input and review of recommendations. The local council may invite the parents to attend meetings at which their child's placement needs will be discussed, according to Maryland officials, and parents have due process appeal rights regarding council recommendations--they can request a formal review if not satisfied. As of December 1985, only 3 of 190 cases processed through the coordinating council process had been appealed, a Maryland official said. In all three cases, the appeal was made, not to refute the placement decision, but to question the quality of the facility the council selected for placement. The councils resolved these appeals by reaching agreement with the parents on the facility chosen.

If the local council approves the agency recommendation for residential care, it is forwarded to the state council for final review and funding. If the state council agrees that residential care represents the least restrictive environment, it will authorize funds from the interagency funding pool to cover the cost of such care; if not, the case is returned to the local council to further explore less restrictive environment options. The various steps in Maryland's placement process are illustrated in figure 2.

Figure 2:

Maryland Process for Residential Placement


HEALTH DEPT. SUBMITS PLACEMENT RECOMMENDATIONS
EDUCATION DEPT. SUBMITS PLACEMENT RECOMMENDATIONS
SOCIAL SERVICES DEPT. SUBMITS PLACEMENT RECOMMENDATIONS
LOCAL COUNCIL DETERMINES IF RESIDENTIAL CARE BEST OPTION
NO
LOCAL COUNCIL PLACES CHILD IN LESS RESTRICTIVE ENVIRONMENT
YES
STATE COUNCIL APPROVES RESIDENTIAL CARE RECOMMENDATIONS
NO
RETURNED TO LOCAL COUNCIL FOR LESS RESTRICTIVE ALTERNATIVE
YES
STATE COUNCIL AUTHORIZES FUNDS FROM POOL

Current Status and Impact

When the Maryland agreement is fully operational, there will be, in addition to the state council, 24 local councils--one in each county and the city of Baltimore. As of December 1985, the state council and nine local councils were active. According to Maryland officials, the remaining local councils are to be in operation by June 30, 1987.

As of December 31, 1985, 190 handicapped children had been referred to the local councils. Of these, the councils placed 40 children in less restrictive environment settings and placement actions on another 70 children were pending at the local councils--awaiting further planning or trying less restrictive environment options.

The remaining 80 children were recommended for residential care to the state council, according to Maryland Education official. Of these, 47 children were approved for residential care and placed, 23 children's cases were pending final approval for residential care, 9 were withdrawn because of subsequent local placement actions, and the remaining case was denied--sent back to the local council to further explore alternate resources at the local level.

A Maryland Education official believes the interagency agreement has a sound legal basis due to the current governor's executive order. But the agreement will have a more permanent legal basis, he asserted, once proposed legislation to require the agreement becomes state law.

STATE VIEWS ON INTERAGENCY AGREEMENTS

Several factors are essential to the effective establishment and implementation of interagency agreements, according to Connecticut and Maryland officials from the various education, health, and social service agencies we visited. Deemed most important were sufficient authority, commitment by agency officials, sufficient planning and lead time, and a commitment of needed resources. All are discussed below.

Sufficient Authority Needed

Authority to enter into interagency agreements should be at a high enough level to assure cooperation by the agencies involved and to obtain a statewide perspective, Maryland and Connecticut officials said. They suggested that agreements be authorized by either the governor's office (e.g., through executive order) or the state legislature (e.g., through state law).

In Connecticut, the third-party billing system could not have been implemented without the governor's authorization and support, a state education agency official said. To implement the billing system, the governor authorized the use of additional state funds to meet the state's matching portion required to obtain federal Medicaid funds. This support enhanced and validated the cooperative relationship between the state's Departments of Education and Income Maintenance.

The Maryland governor's executive order of June 16, 1978, provided the authority to implement the local and state coordinating council process, education officials said. The order recognized the need for a uniform, coordinated statewide approach to serving handicapped children and established a state coordinating committee to develop that approach. The order directed the committee to coordinate its efforts with all state agencies and departments serving handicapped children. According to Maryland Education officials, this was an extremely effective way to validate and encourage interagency cooperation.

Commitment by Agency Officials Required

During our review, we observed that both Connecticut and Maryland officials had a deep commitment to their interagency agreements and believed in them. According to officials in both states, this commitment is particularly important at the upper management level so that the cooperative spirit can have a "ripple effect" down to middle management and those responsible for implementing the agreements.

In Connecticut, it took 4 years to develop the third-party billing system, officials from the Departments of Education and

Income Maintenance said. Tremendous effort for sustained periods by individuals committed to the project was required for it to finally reach implementation. The process calls on individuals to exercise flexibility, persistence, and patience to develop a working rapport and maintain it.

Sufficient Planning, Lead Time Needed

Sufficient planning and lead time to identify and agree upon roles and responsibilities between agencies also is important, Maryland and Connecticut officials explained. This reduces or eliminates barriers to effective communications when trying to establish cooperation and implement interagency agreements. Time is needed for agency representatives to develop rapport with one another and for each to gain an understanding of the other agency's perspective. An understanding of each agency's organization, bureaucracy, priorities, and concerns contributes to a more cooperative and productive atmosphere, Connecticut and Maryland officials believe. Once this has occurred, the group can effectively identify and decide upon each agency's role and responsibility in establishing cooperation and in implementing the agreement. Sufficient lead time is necessary, the officials added, to anticipate any problems that may arise and resolve them before implementation begins.

Commitment of Needed Resources Necessary

Agency representatives responsible for implementing the agreements must be able to commit their respective agencies' funds, state officials told us. For example, under Maryland guidelines, members of the local and state councils must be able to commit the resources of their agencies. In Connecticut, a commitment to increase Department of Income Maintenance Medicaid funds was necessary to enable the third-party billing system to use federal Medicaid dollars. Since agreements imply a sharing of responsibility, it is essential that these resource commitments are made to facilitate the program and encourage further participation, officials of both states believe.

DRAFT LEGISLATIVE LANGUAGE

The subcommittee's letter requesting this review stated that it was not the Congress' intent (in drafting Public Law 94-142) that financial responsibilities previously assumed by health, welfare, and other human services agencies be transferred to state and local educational agencies. The subcommittee asked our assistance in drafting legislative language to (1) clarify financial responsibility for required services, (2) encourage the use of interagency agreements for financing related services to handicapped children, and (3) eliminate impediments to the use of such agreements.

The first three amendments below would amend the Education of the Handicapped Act to clarify financial responsibility for required services and encourage the use of interagency agreements. The fourth amendment, a revision of title XIX of the Social Security Act, would require the availability of Medicaid funds for services that otherwise might not be covered by Medicaid if listed in an individual education plan.

Clarifying Financial Responsibility for Services Required Under Public Law 94-142

The following amendment was not included in our draft report at the time we requested comments from the Departments of HHS and Education. In reviewing their comments and discussing them with subcommittee staff, however, we agreed to develop an amendment to the Education of the Handicapped Act that provides that financial responsibility for services required by Public Law 94-142 is not necessarily limited to education agencies.

Section 612(6) of the Education of the Handicapped Act, as amended (20 U.S.C. 1412(6)), is amended by changing the period at the end thereof to a semicolon and adding the following:

> "Provided, however, that nothing in this Act shall be construed to limit any public health or human services agency from financing some portion of the cost of such services."

Requiring Cooperation of Agencies as a State Goal

To be eligible for assistance under the Education of the Handicapped Act, the amendment below would require a state to include in its state plan policies and procedures that assure establishment of a goal of developing interagency agreements to assist in the education of handicapped children. Such agreements would help ensure that necessary funding was available when needed, that services could be provided more efficiently and expeditiously, and that various agencies could assume a more reasonable and proportional share of costs.

Section 612(2)(A) of the Education of the Handicapped Act, as amended (20 U.S.C. 1412(2)(A)), is amended by deleting "and" after "accomplishing such a goal"; deleting the semicolon after "throughout the State to meet such a goal"; and adding the following:

> ", and (iv) a goal of developing interagency agreements between the state education agency and state and local health and human services and other appropriate agencies to define the financial responsibility of each agency for providing handicapped children with a free appropriate public education."

Encouraging the Development of Interagency Agreements

The following amendment would require eligible states, as defined by the previous section, to incorporate an additional provision into their state plans before funding under the Education of the Handicapped Act could be approved. The additional provision would encourage interagency agreements as discussed above.

Section 613(a) of the Education of the Handicapped Act, as amended (20 U.S.C. 1413(a)), is amended by deleting "and" after "pursuant to section 617;" (subsection 11), deleting the period after subsection 12 and inserting ";and," and adding the following new subsection:

> "(13) provide satisfactory assurance that interagency agreements will be encouraged between the state education agency and state and local health and human services and other appropriate agencies to define the financial responsibility of each agency for educational and educationally related costs necessary to provide handicapped children with a free appropriate public education."

Use of Medicaid Funds for Educationally Related Health Services Required in an Individual Education Plan

Educationally related health services provided to children in special education vary significantly among individual children. Many related services required by individual education plans also are services that fall within the realm of "active treatment" and if not otherwise provided for may become eligible for Medicaid funding. In other words, they may consist of programs and therapy specifically designed to help an individual progress to his or her optimal level of independent functioning.

According to a recent court case, these health services, such as speech pathology and audiology, may be reimbursable under Medicaid even though they are also considered to be educationally related under Public Law 94-142 and included in an individual education plan.

On August 27, 1985, a federal district court in Massachusetts found that certain services provided by the Bureau of Institutional Schools (which administers the educational programs at ICFs/MR) were eligible for reimbursement under the Medicaid program (Massachusetts v. Heckler, C.A. No. 83-2523-G). According to the court decision, the types of services provided by a local school agency to these mentally retarded individuals fell clearly within the category of health services explicitly covered by Medicaid. HHS is appealing this decision.

HCFA, in its September 1985 transmittal pertaining to ICFs/MR clarified its policy, described in an earlier transmittal, on reimbursable services and the distinction between educational and health-related services. It states that all services described in an individual education plan are excluded from Medicaid coverage because they are educational services. HCFA's policy was developed prior to the Massachusetts court decision and may have to be revised if the case is upheld on appeal. A Connecticut official expressed concern to us that, were the policy described in this HCFA transmittal extended beyond intermediate care facilities to the local public schools, it could threaten the state's interagency agreement for Medicaid reimbursement of school-based child health services.

To modify the effect of the HCFA policy and allow Medicaid funds to be spent for educationally related health services to handicapped children as well as nonhandicapped children without regard to their inclusion in an individual education plan, we drafted legislative language below, as requested.

Title XIX of the Social Security Act is amended by adding the following new section 1919 (42 U.S.C. 1396r):

> "Notwithstanding section 1902(a)(25) of the Social Security Act, "Related Services", as defined in section 602(17) of the Education of the Handicapped Act, as amended (20 U.S.C. 1401(17)), provided to a handicapped individual shall be paid under this title to the extent that they would have been paid had the services not been listed in an individual education plan."

This amendment does not obligate Medicaid to pay for traditional educational services, nor does it prohibit Medicaid coverage for health services included in the IEP of a handicapped child. But while, Medicaid is predominately a federally funded program, education is largely funded at the local level. Thus,

this amendment, if passed, could result in some shifting of health care costs from local education agencies to the federal government, if indeed education officials currently are paying such costs. The extent of this shift is impossible to estimate in any reliable way.

COMMENTS BY THE DEPARTMENTS OF HEALTH AND HUMAN SERVICES AND EDUCATION

The Departments of Health and Human Services and Education, to whom we sent a draft copy of this report for their review, focused their comments on the proposed legislation regarding the use of Medicaid funds for educationally related health services included in a handicapped child's IEPs.

In its comments (see app. I), HHS expressed general opposition to any amendment to the Social Security Act that would shift "state education costs" to the Medicaid budget. HHS stated that (presumably under present law) Medicaid funds may not be used for educational activities, even if such care would otherwise be covered under Medicaid. The department stated that section 1902(a)(25) of the Social Security Act, which requires states to seek payment from all third-party payers, precludes federal Medicaid reimbursement where other funding is available. HHS also believed that our report inaccurately characterized the relationship between the existing Medicaid program and state activities with regard to education of the handicapped. For example, HHS stated, the Connecticut program for maximizing third-party reimbursement conflicts with HCFA's instruction to states on coverage of education and related services, and the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272) affirms HHS' views that "education and related services" are excluded from coverage under the Social Security Act.

The Department of Education also provided comments to our draft report (see app. II). Education stated that our draft amendment regarding the use of Medicaid funds is in conflict with present law under the Social Security Act's provisions concerning payment for services for which third parties are responsible. To the extent that education and related services are provided in a handicapped child's individual education plan, Education said, these costs should be the responsibility of the state education agency, not Medicaid.

Discussion of Agency Comments

We believe HHS incorrectly characterized our draft amendment regarding the use of Medicaid funds. The amendment is not intended to shift traditional education costs to the Medicaid budget. Rather it deals with health services, such as speech pathology and audiology that are included in a child's individual education plan, not traditional education expenses. The implication of the amendment is that, regarding Medicaid reimbursement of health care costs, handicapped children would be treated in the same way as children who are not handicapped.

The suggested amendment to the Social Security Act (Medicaid) concerning related services is intended to allow funding

for services that Medicaid would have funded in the absence of Public Law 94-142. HHS and Education believe the draft amendment may conflict with the current language of the Social Security Act's provisions that precludes federal Medicaid payments for services for which third parties are liable. We are aware of the Social Security Act's provisions and have always supported Medicaid as the payer of last resort. While it is not clear whether state educational agencies should be considered liable third parties under section 1902(a)(25), this draft legislation would, if state education agencies can be considered liable third parties, alter the principle of Medicaid as the payer of last resort.

We should also point out that we neither support nor oppose any change. We are merely complying with the request that we provide the subcommittee with legislative language so it can consider possible changes.

HHS said that section 9502 of the Reconciliation Act reaffirms its views that education and related services should not be paid through Medicaid. Section 9502 specifically excludes from coverage "special education and related services," as defined in the Education of the Handicapped Act, for individuals discharged from a skilled nursing facility or intermediate care facility to the extent that the services are available through a local education agency. The language in the Reconciliation Act is limited to services provided to individuals discharged from two types of health facilities. There is still a question, however, as to whether payment for all education-related health services provided to handicapped individuals who remain in these facilities is to be the responsibility of state education agencies because the services were listed in an individual education plan. The draft amendment is intended to assist the Congress should it desire to clarify this situation.

Although Public Law 94-142 designated the state educational agency as responsible for assuring that handicapped children receive a free appropriate public education, it did not make the state educational agency solely liable financially for all services provided nor preclude financial participation by other agencies. The legislative history indicates that all sources of funds should be used.

The Senate report accompanying Public Law 94-142 states that ". . . the State educational agency is responsible for assuring that funds for the education of handicapped children under other Federal laws will be utilized . . ." Elsewhere in the Senate report, explicit reference to funding from other sources is mentioned. For example, it states that

". . . there are local and State funds and other Federal funds available to assist in this [education] process. Any funds available from the Federal Government are clearly in addition to funds provided under this Act and are available to States to assist them in carrying out their responsibilities under State laws, State Constitutions, and the U.S. Constitution, and should be so utilized."

At the subcommittee's request, we added draft legislation providing that financial responsibility for services required by Public Law 94-142 is not necessarily limited to education agencies. This amendment was added to the report after the Departments of Education and HHS provided their written comments. We subsequently gave HHS and Education an opportunity to comment on this additional draft amendment. Neither agency chose to add to their May 5, 1986, written comments.

With regard to HCFA's instruction (Transmittal No. 16, Sept. 1985) on coverage of education and related services, we do not believe this instruction is applicable to the Connecticut situation. HCFA's instruction pertains to ICFs/MR and prohibits Medicaid from paying for educational services provided at these facilities. In Connecticut, education agencies are being reimbursed by Medicaid for health-related services provided in the school setting--not for educational services in an ICF/MR.

In commenting on our draft amendments that encourage the use of interagency agreements, HHS said that the Social Security Act already requires state Medicaid agencies to enter into interagency agreements. Education does not believe these amendments are needed because its regulations already provide for such agreements.

We are familiar with the Medicaid state plan requirements under section 1902(a)(11)(A) of the act and the regulations concerning state assistance for education of handicapped children under 34 C.F.R. § 300.301. However, section 1902(a)(11)(A) does not address educationally related health services, and 34 C.F.R. §300.301 is permissive and unlike our proposed amendment does not encourage agreements or require states to establish procedures that would facilitate the process. Accordingly, the proposed amendments require the states to take action that would encourage the development of agreements for funding educationally related health services.

ADVANCE COMMENTS FROM THE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

MAY 5 1986

Mr. Richard L. Fogel
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

The Secretary asked that I respond to your request for the Department's comments on your draft report, "Financing Services for Handicapped Children in Connecticut and Maryland." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Bryan Mitchell
For Richard P. Kusserow
Inspector General

Enclosure

Comments of the Department of Health and Human Services on the General Accounting Office Draft Report, "Financing Services for Handicapped Children in Connecticut and Maryland"

GAO Findings

GAO conducted this review at the request of the Chairman, Subcommittee on Select Education, Committee on Education and Labor, House of Representatives, in response to concern that the Education for all Handicapped Children Act (P.L. 94-142) has resulted in State and local education agencies assuming increased responsibility for financing various services to handicapped children. GAO briefed the Chairman's office on the information it obtained and discussed the use of interagency agreements by States as a method of utilizing the resources of a variety of State agencies to help serve handicapped children. At that briefing, GAO agreed to obtain information on the use of such interagency agreements in Connecticut and Maryland. In addition, GAO agreed to draft legislative language that would encourage interagency agreements and eliminate perceived legislative impediments to their use.

GAO reports that, overall, the interagency agreements in both States demonstrate that State agencies with various responsibilities for serving handicapped children can work together and share the cost of services provided. In Connecticut, a State education official estimated that about $5 million per year in Medicaid reimbursements will be made to local school districts for school based health services provided to handicapped children. This represents a $2-3 million shift from non-federal funding sources to the Federal government. In Maryland, GAO was advised that the interagency agreement has resulted in education, health and social service agencies contributing over $11 million to a fiscal year 1986 State funding pool to cover the costs of placing handicapped children in residential care facilities.

GAO has included legislative language in its report which encourages the use of interagency agreements through revision of P.L. 94-142. In addition, in response to the concern that Medicaid may be precluded from funding health related services solely on the basis that such services are listed in a handicapped child's individual education plan, GAO included legislative language which amends title XIX of the Social Security Act (Medicaid) to specifically allow the use of Medicaid funds for health services that would otherwise be covered if not listed in an individual education plan.

Department Comments

The report does not accurately characterize the relationship between the existing Medicaid program and the State activities with regard to education for the handicapped. For example, the Connecticut program for maximizing third party reimbursement conflicts with the Health Care Financing Administration's instruction on coverage of education and related services. Further Connecticut's program

ignores long-standing Medicaid statutory provisions, regulations (42 CFR 441.13(b)), and the State Medicaid Manual (section 4396, part 4) which precludes Federal Medicaid reimbursement where other funding is available. Section 1902(a)(25) of the Social Security Act requires States to seek payment from all third party payers. The report reflects the erroneous view that services which are covered under P.L. 94-142 and covered under Medicaid may be billed to Medicaid. As noted above, certain services must be provided to handicapped individuals by States under P.L. 94-142. Federal Medicaid funds may not be used for these educational activities, even if such care would otherwise be covered under Medicaid. If such services are provided to an individual during a period when the State educational system is not responsible for the individual (i.e., summer, evenings) or as a supplemental activity to reinforce formal State educational training, the service is then eligible for Medicaid reimbursement. Although there have been efforts in Congress to gain Medicaid funding for services such as those for which Connecticut is apparently claiming Federal financial participation, section 9502 of the Consolidated Omnibus Budget Reconciliation Act of 1985 affirms our views about the existing education and related services exclusion.

We defer to the Department of Education concerning changes to P.L. 94-142 to encourage interagency agreements. We do not believe, however, that it is consistent with P.L. 94-142 for any agency other than the State education agency to be given statutory responsibility, as suggested in these amendments, for providing a free appropriate public education. We would also note that section 1902(a)(11)(A) of the Social Security Act already requires State Medicaid agencies to enter into interagency agreements to maximize the level of services available to eligibles by utilizing services from other agencies. Finally, we oppose any amendment to Medicaid which would shift State education costs to the Medicaid budget as suggested in GAO's draft legislative language.

ADVANCE COMMENTS FROM THE DEPARTMENT OF EDUCATION

UNITED STATES DEPARTMENT OF EDUCATION
OFFICE OF THE ASSISTANT SECRETARY
FOR SPECIAL EDUCATION AND REHABILITATIVE SERVICES

MAY 5 1986

Mr. Richard L. Fogel
Director
Human Resources Division
General Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

For our review and comment, you have provided us with a copy of the draft report, "Financing Services for Handicapped Children in Connecticut and Maryland," that was prepared by the General Accounting Office. The draft report describes information obtained on the use of interagency agreements in two states and provides draft legislative language to encourage interagency agreements and eliminate impediments to their use.

As the Federal agency charged with the administration of Part B of the Education of the Handicapped Act (EHA-B), as amended, the Department of Education supports the goal of providing appropriate special education and related services to handicapped students in the most efficient and effective manner possible. EHA-B recognizes that many handicapped children require "related services" to enable them to benefit from special education. The Department of Education supports actions which assist in the education of handicapped children inasmuch as they enable related services to be provided more efficiently and cause the various State agencies to work together to plan programs for individuals and, where appropriate, share costs.

The GAO draft report proposes legislative language to provide for the use of Medicaid funds for related services as defined in the EHA required in an individual education plan (IEP). The Department recognizes that Medicaid is a matter for a sister agency (the Department of Health and Human Services); however, the proposed statutory amendment would appear to be in conflict with the Social Security Act's statutory provisions concerning payment for services for which other third parties are responsible as discussed in section 1902(a)(25) of the Social Security Act, and title 42, CFR 433.139 and 433.140. To the extent that education and related services are provided in a handicapped child's IEP, we believe these costs should be the responsibility of the Education Agency and not Medicaid.

The GAO draft report also proposes two amendments which would amend the State Plan and Eligibility requirements under EHA to require the States to establish a goal of interagency agreements and to encourage that such agreements be used to define the

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APPENDIX II

financial responsibility of various agencies. In principle, the Department does not oppose these amendments as a way of encouraging States to develop and formalize interagency agreements to define the financial responsibility of each agency. However, current program regulations (34 CFR 300.301) already provide for such agreements. Though these amendments are not, therefore, needed, GAO should in its report note to the Congress that any such amendments be modified to make it clear that this language is not to be used to authorize Medicaid reimbursement of services delineated in an IEP.

I appreciate the opportunity to review the report and hope these comments are helpful to you. Please do not hesitate to contact me if I may be of assistance.

Sincerely,

Madeleine Will

Madeleine Will
Assistant Secretary

(104567)

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